Bearsted Medical Practice

Quality Report

The Surgery,
Yeoman Lane,
Bearsted,
Maidstone,
Kent. ME14 4DS
Tel: 01622 737326
Website: www.bearsted.gpsurgery.net

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Summary of findings

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Summary of findings

Overall summary

The Bearsted Medical Practice provides primary medical care during week-day surgery hours for patients in the Bearsted area of Maidstone in Kent. The practice has eight general practitioners (GPs), who form the registered partnership. The services are commissioned by the West Kent Clinical Commissioning Group (CCG).

We spoke with patients during our inspection, and they were all very complimentary about the services they received from the practice. We received many positive comments from the patients who had completed comment cards prior to our inspection. They all expressed a high level of satisfaction with the practice and staff. We spoke with the Patient Participation Group (PPG) representative, who emphasised the support, engagement and effective working relationship the group had with the practice management team. Staff we spoke with told us the management team were very open and approachable and that there was good team working amongst all the staff at the practice.

Although the practice provided safe care, we suggested that some changes could be made in relation to how medicines were managed. We also suggested some changes could be made in the practice about the procedures used to monitor and manage infection control. In addition, we had concerns about insufficient documented information in relation to pre-employment checks for some of the staff. We found that whilst the staff at the practice had received training in safeguarding children, the records showed that only one member of staff had received training in safeguarding vulnerable adults. However, the staff we spoke with were able to demonstrate their knowledge of how to recognise suspected abuse and who to report any concerns to.

We found that the practice was well-led and provided caring, effective, and responsive services to a wide range of patient groups, including those of working age and recently retired, mothers with babies and younger children, older people, patients with long-term conditions and complex needs, people in vulnerable circumstances and those people experiencing poor mental health. We considered that the concerns we had regarding safety at the practice, had an impact across all patient groups.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice had policies and procedures in place to help ensure the safety of care provided to patients. This included health and safety arrangements, safeguarding procedures and systems to enable the practice to respond to emergencies and manage risks.

We found that the practice did not have sufficient controls and procedures in place to manage medicines safely and that patients were not always protected from the risks associated with medicines. We also found that the practice did not always have appropriate infection control procedures and systems in place to minimise the risks of cross infection for patients.

We found that the practice had a robust recruitment policy and appropriate professional/safety checks had been carried out when staff were recruited. However, we found that the policy had not been followed, as some staff files did not contain sufficient documented information about the staff employed at the practice to ensure that their full employment history and identity had been robustly checked before they were employed.

Are services effective?

Patients experienced an effective service. There were measures in place to monitor the delivery of treatment and clinical audits were used to review and improve outcomes for patients. Patients consistently told us that their health care needs were met to a high standard and in a timely manner.

Are services caring?

Patients experienced a caring service. We found that patients were treated with dignity and respect. Patients we spoke with and comments we received were all positive, with patients stating that they were very happy with the services they received. Most of the patients we spoke with had been using the practice for many years and said they would recommend the practice to other people.

Are services responsive to people's needs?

The practice was responsive to patients' needs. There were mechanisms in place to respond and take action when things did not go as well as expected. There was a complaints process and responses were made in a timely manner. Patients were given the opportunity to make suggestions to improve the services provided and they were listened to and actions had been taken to make changes where practicable to do so.

Summary of findings

Are services well-led?

The practice was well-led. The management team provided open and visible leadership to the staff and there were clear lines of accountability and responsibility within the practice. There were mechanisms in place to disseminate information to the staff and procedures for reporting up the line management structure.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Although we found that most of the staff had not received specific training for the safeguarding of vulnerable adults, they were able to demonstrate their awareness of the procedures to follow if any concerns were identified.

We saw that the practice offered annual flu vaccinations routinely to older people to help protect them against the virus and associated illness.

We found the practice to be caring in the support it offered to older people and there were effective treatments and on-going support for those patients identified with dementia. The practice was responsive in meeting the needs of older people and in recognising future demands in service provision for this age group. The practice was well-led in relation to identifying a named lead doctor to train in specialist dementia care and in recognising symptoms to enable early detection. There was a care manager from social services based at the practice which encouraged a joint approach to care for this population group.

People with long-term conditions

We found the practice to be caring in the support it offered to patients with long-term conditions and that the care provided was effective, treatment pathways were monitored and kept under review by a multi-disciplinary team. We saw that the practice offered annual flu vaccinations routinely to people who may be at greater risk due to long term conditions, to help protect them against the virus and associated illness.

The practice was responsive in prioritising urgent care that people required and the practice was well-led in relation to improving outcomes for patients with long-term conditions and complex needs.

Mothers, babies, children and young people

There were systems and procedures at the practice to ensure that information received from other service providers was used to improve safety for babies, children and young people.

We found that the practice was caring in its approach to mothers, babies, children and young people and provided effective treatments, offering dedicated services at the practice and referrals to other community based services to provide additional support.

Summary of findings

The practice provided a responsive service, prioritising appointments for mothers with babies and young children. The practice was well-led in relation to nominating a named lead to have overall responsibility for children's safeguarding.

The working-age population and those recently retired

We found the practice to be caring in the support it offered to working age and recently retired people, and were responsive in reviewing opening hours. There was effective monitoring of services and the management team completed audit cycles to evaluate and improve outcomes for patients in this group

People in vulnerable circumstances who may have poor access to primary care

We found that the practice was caring about vulnerable patients, in particular, the premises were accessible and suitable for patients with reduced mobility. However, the height of the reception desk was not considerate to patients who used wheelchairs. We saw that the practice offered annual flu vaccinations routinely to vulnerable people as they may be at greater risk of infection, to help protect them against the virus and associated illness. There was effective support from the practice for vulnerable people in the community and the practice was responsive in providing care and treatment at patients' homes who found it difficult to attend the practice

People experiencing poor mental health

We found the practice had a caring approach to patients who may be experiencing poor mental health and the practice had effective procedures in place for undertaking routine mental health assessments. They were responsive in referring patients to specialist mental health service providers for on-going support. Management provided a well-led approach in relation to identifying and managing risks to patients who may be experiencing poor mental health.

Summary of findings

What people who use the service say

All the patients we spoke with during our inspection were very positive about the services they received from the practice. They were particularly complimentary about the staff, and said that they were always caring, supportive and sensitive to their needs.

We also received many positive comments from patients who had completed comment cards prior to our inspection, all expressed a high level of satisfaction with the service they had received from the practice and about the staff. We also spoke with the Patient Participation Group (PPG) representative, who emphasised the support, engagement and effective working relationship they had with the practice management team.

Areas for improvement

Action the service MUST take to improve

The practice must undertake a review of the information collected and checked when staff have been recruited and employed and how this is to be recorded in staff files. Some staff files did not contain sufficient information about the staff employed, for example, photographic ID, references and employment history.

Action the service COULD take to improve

The practice could review the management of medicines at the practice, including those medicines kept and used for emergencies and medicines stored in the dispensary. There could be:

- systems and processes for the security and control of prescription pads
- records and evidence of checks of the emergency equipment/medicine stocks kept on the premises and issued to GPs
- records and evidence of checks of the equipment/ medicine stocks kept/stored in the dispensary
- a written protocol/risk assessment for access/security of the dispensary, including how the space/ environment is used

The practice could review the systems and procedures relating to infection control. There could be:

- detailed cleaning schedules that identify the cleaning checks undertaken in treatment rooms throughout the day
- records and evidence of an audit programme in accordance with the hygiene code - that identifies how the practice monitors and manages issues relating to cleanliness and infection control

Bearsted Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector and a GP Specialist Advisor. The team included a Practice Manager as well as an Expert by Experience.

Background to Bearsted Medical Practice

Bearsted Medical Practice provides medical care Monday to Friday from 8.30am to 6pm, with extended opening hours on certain mornings/evenings, for patients in the Bearsted area of Maidstone in Kent. The practice provides a service for approximately 12,700 patients in the locality and has a dispensary service for those patients who may find it difficult to access a local pharmacy.

Routine health care and clinical services are offered at the practice, led and provided by the clinical nurse team. There are a range of patient population groups that use the practice.

The practice has eight GPs, up to three trainee GPs, as this is a training practice, four practice nurses, a practice manager, four health care technicians, for blood tests, blood pressure tests, ECG's, new patient checks and NHS health checks, and three dispensers. A team of community nurses and a social services care manager also has a base within the practice, which provides ease of access for patients referred to these services.

Why we carried out this inspection

We inspected this practice as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

The inspection team always looks at the following six population areas at each inspection:

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problem.

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew about the practice. This included the local Clinical Commissioning Group (CCG) and Local Healthwatch. We carried out an announced visit on 20 May

Detailed findings

2014. During our visit we spoke with a range of staff, including four GPs, three clinical staff, the practice manager, and three reception and administration staff. We spoke with ten patients who used the service and reviewed comment cards where patients and members of the public shared their views and experiences of using the practice. We also spoke with a representative from the 'Patient Participation Group' (PPG). We observed how patients were supported by the reception staff in the waiting area before they were seen by the GPs.

Are services safe?

Summary of findings

The practice had policies and procedures in place to help ensure the safety of care provided to patients. This included health and safety arrangements, safeguarding procedures and systems to enable the practice to respond to emergencies and manage risks.

We found that the practice did not have sufficient controls and procedures in place to manage medicines safely and that patients were not always protected from the risks associated with medicines. We also found that the practice did not always have appropriate infection control procedures and systems in place to minimise the risks of cross infection for patients.

We found that the practice had a robust recruitment policy and appropriate professional/safety checks had been carried out when staff were recruited. However, we found that the policy had not been followed, as some staff files did not contain sufficient documented information about the staff employed at the practice to ensure that their full employment history and identity had been robustly checked before they were employed.

Our findings

Safe patient care

We saw that a system was used by the reception staff to alert the GPs to patients waiting to be seen that were potentially at increased risk and should therefore be prioritised, for example, if they had chest pain or when young children were waiting. Systems were also in place to process urgent referrals to other care/treatment services and to ensure test results were reviewed promptly once received by the practice. For example, a 'buddy' system was used by the GPs to check test results and clinical information during any absence. We were told by clinical staff that the computer system flagged up an 'alert' for babies and young children who had been placed on the 'at risk' register to ensure that these patients were adequately monitored to protect them from abuse.

The practice had a health and safety policy which was underpinned by processes and systems to keep the premises and building safe for patients, staff and visitors. Records showed that service and maintenance contracts were in place with specialist contractors, who undertook regular safety checks and maintained specialist equipment. For example, boiler, lift, and security alarm servicing and tests of clinical equipment. The premises had an up-to-date fire risk assessment and regular fire safety checks were recorded and staff training had been provided in respect of fire safety awareness.

Learning from incidents

The practice had mechanisms to report and review significant events and reportable incidents. Staff we spoke with explained the procedure they would follow to report incidents and records showed that these were discussed with all GPs at regular team meetings. Meeting notes identified outcomes of significant events, action points to address and learning points for the practice. We saw examples of how changes were implemented as a result.

Safeguarding

The practice had an up-to-date safeguarding policy in respect of children and vulnerable adults and included detailed procedures and guidance for staff to follow, that raised awareness to the risks associated with abuse and the signs that might indicate abuse had occurred. Staff we spoke with told us that they were aware of the policy, explained how they would recognise the signs and symptoms of abuse, the procedure to report any concerns,

and that they had received safeguarding training. There was information displayed around the practice that identified the contact details of the named lead for safeguarding and we saw evidence that safeguarding reviews were undertaken following information received about patients from other service providers. There were also contact details of external authorities that staff may need to contact. The practice had a whistleblowing policy and staff told us they were aware of the procedure to follow if they wished to raise concerns outside of the practice. We saw evidence that staff had received training in safeguarding children, however, records showed that only one member of staff had received training for safeguarding vulnerable adults.

The practice had a chaperone policy setting out the arrangements for those patients who wished to have a member of staff present during clinical examinations or treatment. The policy clearly stated that only those staff that had received appropriate training and had undergone a criminal records check via the Disclosure and Barring Service (DBS) would be able to chaperone patients. This meant that potential risks to patients had been minimised by the practice.

Monitoring safety and responding to risk

The practice had systems and procedures in place for responding to emergencies and all the staff within the practice had received training in emergency life support. Weekly clinician meetings were held and we saw evidence of how decisions were made about on-call and cover arrangements to ensure there were sufficient hours provided for patient sessions, including emergency appointments.

We spoke with clinical staff that were experienced in prioritising appointments and worked with the GPs to ensure patients were seen according to the urgency of their health care needs. An 'on-call' GP was also available in the practice each week-day to support service demands, providing greater flexibility amongst the GPs to respond to busy periods and any emerging risks to patients throughout the day.

We saw that the practice had panic buttons and a safety alert system in all treatment areas to enable staff to summon assistance if needed. This meant that the practice was able to respond quickly when an emergency situation arose and staff told us they were aware of the emergency procedures to follow.

Medicines management

The practice had a named prescribing lead, who was responsible for the management of medicines. We spoke with a member of the clinical team who told us that the practice had a system for checking that repeat prescriptions were issued according to the medicine review date for each patient, to ensure that patients on long-term medication were seen and their medicines reviewed on a regular basis. We saw that the practice had a prescription security policy that set out how prescription pads were issued to clinicians. However, this did not reflect who was responsible for monitoring prescription pad stocks and records did not show the individual prescription pad numbers issued and in use within the practice. There was no record of which GP had which prescription pad, or a record of the prescription pads that had been used.

We checked some of the vaccines held in the fridge and found them to be within usable date, although we found that no records were kept to demonstrate that expiry dates were routinely checked. Records showed that fridge temperatures were routinely checked and a written protocol was available for staff guidance, to help ensure the required temperatures were maintained for stored vaccines. We spoke with staff who told us the actions they would take if problems arose regarding storage temperatures.

We looked at the medicines and equipment kept on the emergency response trolley and found that whilst the medicines were within usable date, records were not kept to identify the stocks held or to demonstrate that expiry dates were routinely checked. We also saw that one medicine was noted as 'awaiting new stock'. We checked the emergency medicines kept in a GPs' bag and found that checks were not undertaken to monitor and record the medicines held.

We looked at the arrangements for the dispensing of medicines to patients. We spoke with dispensing staff, who had received appropriate training in pharmacy services. An up-to-date 'Standard Operating Procedure' was in place for staff guidance and a risk management protocol had been recently reviewed. Medicines were prepared, and the prescriptions checked and counter-signed by GPs on a daily basis before being collected/issued to patients. However, we saw that the dispensary room was generally cluttered, with paperwork and bags stored around and on the sink draining area. Sharps containers were stored on

the floor under work surfaces, many were full and awaiting collection, and not all had audit labels completed to identify their origin and the date sealed. Staff told us that an annual stock check was undertaken, and expiry dates were checked, although there were no records of this and could not therefore be evidenced. We saw that a large bin contained a number of medicines awaiting collection for disposal by the contracted supplier, who signed to confirm collection. Security procedures for the dispensary were not formally recorded, for example, to identify how and when the room was locked and who had access. We saw that the dispensary had appropriate arrangements for the secure storage of controlled drugs, including the control of keys, a separate drugs register and two signatures recorded when dispensed.

Cleanliness and infection control

The practice had an infection control policy, which included a range of procedures and protocols for staff to follow, for example, hand hygiene, clinical waste, and personal protective equipment (PPE). We saw that these were displayed in the treatment rooms to raise staff awareness. Treatment rooms contained sufficient supplies of liquid soap, sanitiser gels, anti-microbial scrubs and disposable paper towels for hand washing purposes. There were foot-operated waste bins and we saw that domestic and clinical waste products were segregated. Sharps containers were date labelled, not over-filled and disposable privacy curtains were date labelled to identify when they were replaced. The chairs in the treatment rooms were fabric covered and although they appeared clean, there was no evidence available to demonstrate how these were effectively cleaned to prevent the spread of infection.

The infection control policy stated that an annual infection control audit would be undertaken, however, we were told by the staff that an audit had not been completed within the previous twelve months and there was no evidence available of any previous audits that had been undertaken.

We spoke with clinical staff who told us that they followed a cleaning schedule in the preparation and cleaning of treatment rooms at the start and end of each day and between patients. We looked at the schedule and saw that this included a list of actions to be undertaken, although this was a laminated sign displayed on the wall and did not therefore provide a detailed daily record that was signed/dated by staff to confirm that the actions had been completed.

Staffing and recruitment

We looked at staffing levels within the practice and spoke with the practice management who told us that there was adequate flexibility and availability amongst the clinical team to safely absorb staff shortages and absence without necessarily using locum or agency staff. However, we spoke with some of the clinical staff who told us that they had very little 'protected' time outside of patient appointments to undertake additional tasks to help ensure patient safety. They said this included re-stocking and preparing treatment rooms with essential items, checking clinical equipment and monitoring/checking medicine stock levels.

The practice had a recruitment policy that reflected a robust recruitment and selection process. We looked at a selection of staff files and saw that appropriate criminal record checks had been carried out with the Disclosure and Barring Service (DBS), as well as professional registration checks for all clinical staff with the National Midwifery Council (NMC) or the General Medical Council (GMC). However, some staff files did not contain sufficient documented information about the staff employed at the practice, for example, photographic ID, references and employment history.

Dealing with Emergencies

The practice had an emergency and business continuity/recovery plan that included arrangements detailing how patients would continue to be supported during periods of unexpected and/or prolonged disruption to services. For example, severe bad weather that caused staff shortages, interruption to utilities, or unavailability of the premises. The practice also had systems in place to recognise future demands that may be placed on the practice, for example, using information and intelligence to plan for the needs of older people and the prevalence of dementia.

Are services effective?

(for example, treatment is effective)

Summary of findings

Patients experienced an effective service. There were measures in place to monitor the delivery of treatment and clinical audits were used to review and improve outcomes for patients. Patients consistently told us that their health care needs were met to a high standard and in a timely manner.

Our findings

Promoting best practice

We spoke with clinical staff who told us that patients' needs and potential risks were assessed at initial consultations with the clinicians, individual clinical and treatment pathways were agreed and recorded on the computerised system. There was evidence that the practice carried out medicine audits that had been initiated by NHS commissioners/stakeholders in line with national guidelines and standards. For example, we saw that a change had been made to the prescribing regime for patients with a specific condition, following updated best practice guidelines.

We spoke with clinical staff who demonstrated an awareness of the rights of patients who lacked capacity to make decisions and give consent to treatment. They told us that mental capacity assessments were carried out by the GPs and recorded on individual patient records and mental health reviews were undertaken when patients visited the practice for other routine checks. We saw evidence that the practice had a protocol for the consent to treatment and a form was used to gain the written consent of patients when undergoing specific treatments, for example, immunisations. We saw evidence that one member of staff had undertaken mental capacity awareness training.

Management, monitoring and improving outcomes for people

The practice used information to analyse the effectiveness of some of the treatments provided to patients and registers were kept to identify patients with specific conditions/diagnosis, for example, patients with dementia. We saw evidence that clinical audits were undertaken and comparisons made against the results that would be expected on a national basis. The information was shared and discussed at clinical meetings and actions agreed regarding changes to specific treatments and therapies that would potentially achieve improved outcomes for patients.

Staffing

We saw evidence, and the staff we spoke with told us, that there were processes in place for managing performance and professional development. Records showed that the clinical team were appropriately qualified and supported to access on-going training and development appropriate

Are services effective?

(for example, treatment is effective)

to their role, for example, specialist training in diabetes and up-to-date training in childhood immunisation. Clinical staff told us they attended external forums and events to help ensure their continual professional development. We saw evidence that staff received an annual appraisal to review their performance and to identify additional/ on-going learning needs. We saw that an induction programme had been undertaken by a member of staff who had recently joined the practice. This meant that the practice had ensured staff were appropriately trained in their roles to support the health care needs of patients.

Working with other services

We saw evidence that the practice maintained links with community nursing teams, for example, specialist mental health nurses, the long-term conditions nurse and the palliative care team. Multi-disciplinary meetings were held each week and included clinicians from the practice, social services and community teams involved in patient care/ treatments. This meant that the practice worked with other care providers and partner agencies, to promote integrated and co-ordinated care pathways for patients, to help ensure all their needs were met.

A social services care manager and a community nursing team were based within the building, enabling ease of access and information to be shared between different service providers, to promote a co-ordinated approach to the care/treatment that patients received. The premises were used by external agencies to deliver a range of care and treatments, including foot care, counselling/ psychology support and a hearing-aid clinic.

Health, promotion and prevention

The staff we spoke with told us that there were a range of services provided to promote health and well-being for patients, including routine health checks, follow-up checks for patients with long-term conditions, vaccinations and screening programmes, such as women's health and eye care. These were managed by a re-call system to help ensure patients received on-going preventative care and support from the practice. Patients we spoke with told us that they were contacted by the practice to attend routine checks and follow-up appointments regarding test results.

Are services caring?

Summary of findings

Patients experienced a caring service. We found that patients were treated with dignity and respect. Patients we spoke with and comments we received were all positive, with patients stating that they were very happy with the services they received. Most of the patients we spoke with had been using the practice for many years and said they would recommend the practice to other people.

Our findings

Respect, dignity, compassion and empathy

All the patients we spoke with told us that they felt the staff at the practice treated them with respect and were polite, and we observed this during our inspection. Patients said that staff considered their privacy and dignity and we saw notices informing patients that they could ask for a chaperone if they wished to. Patients said that staff were considerate and caring and that they were shown compassion and understanding by the clinicians when they received treatment. Some patients told us that the practice provided them with emotional support when they were dealing with difficult situations and staff were always sensitive in the way they communicated with them. The staff we spoke with demonstrated how they considered patients' privacy and dignity during consultations and treatments, by ensuring that doors were closed and curtains were used in treatment areas to provide additional privacy.

The practice had a confidentiality policy that staff were required to sign, in agreement to protecting patient information. Staff were clearly aware of their responsibilities in maintaining patient confidentiality. We observed that confidentiality had been considered in the general waiting area, as patients were required to stop and wait some distance from the reception desk, to provide some degree of confidentiality for patients speaking with the staff.

Involvement in decisions and consent

Patients told us that they felt involved in the decisions that were made about their care and treatment. They said that clinicians had time to listen, explained things well and that they were able to ask all the questions they wanted to about their care and treatment. Patients told us they could choose which GP they wished to see, although they acknowledged that they may have a longer wait to see the GP of their choice. We saw that the practice had a range of leaflets and sign-posting documents displayed for patient information, to help ensure patients were made aware of the options, services and other support available to them. We spoke with staff who explained the discussions that took place with patients, to help ensure they had an

Are services caring?

understanding of their treatment options. They told us that forms were used to record patient consent and that this information was also recorded on individual patient records on the computer system.

The practice had a Patient Participation Group (PPG) who organised and co-ordinated regular meetings and patient surveys. We spoke with a representative from the group who told us that they were supported and encouraged by the management to ensure patient views, comments and feedback were captured on a regular basis, to help inform some of the decisions made about how services were provided. We looked at the most recent survey results and saw that the majority of comments were positive and some of the suggestions had already been implemented within the practice. For example, following requests and comments from patients, chairs in the waiting area had been re-arranged to provide more space, a cooling fan and cold drinking water had also been put in place. Patients told us that this had improved the comfort and safety of the waiting area for patients and others who used the practice. The practice had an online website containing a dedicated section for the PPG, where recent surveys, meeting minutes and the group's annual report could be accessed by patients and members of the public. There was also a facility to access an online survey form where feedback and comments could be submitted. This meant that the practice involved patients in a meaningful way about the services and facilities they received.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

Overall, the practice was responsive to patients' needs. There were mechanisms in place to respond and take action when things did not go as well as expected. There was a complaints process and responses were made in a timely manner. Patients were given the opportunity to make suggestions to improve the services provided and they were listened to and actions taken to make changes where practicable to do so.

Our findings

Responding to and meeting people's needs

The practice maintained links with local area commissioners and we were told that meetings took place on a regular basis to review and plan how the practice would continue to meet the needs of the patients and potential changes in service demands in the future.

The staff we spoke with explained that a range of services were available to support and meet the needs of different patient groups and that they would refer patients to community specialists or clinics if appropriate. For example, referring mothers with babies and young children to the community health visitor and older people to specialist groups who supported people with dementia and associated physical problems. The practice worked closely with community nursing teams, including the long-term conditions nurse and the mental health nurse who undertook mental health assessments and offered memory clinics each month to those patients referred by the practice. Patients said they were referred promptly to other services for treatment, test results were available quickly and some patients spoke positively about minor surgical procedures and operations that they had undergone at the practice.

The premises were seen to be accessible for disabled patients, having level access and disabled parking spaces close to the entrance door. A disabled toilet was available and a lift provided access to the first floor. There were also baby changing facilities for mothers with babies to use. However, we saw that the reception desk did not have a lowered area to accommodate patients using wheelchairs who may have found it difficult to communicate easily with the reception staff. We observed staff coming out from behind the reception desk to speak with patients when they realised they were there.

Access to the service

The practice had introduced a 'walk-in and wait' system each week-day morning, where patients were not required to make appointments. Patients we spoke with told us that they found the system worked very well for them, even though there was sometimes a long wait to be seen, particularly if they had expressed a choice of GP they wished to see. However, they were positive about the reassurance the system gave them in knowing they would be able to see a GP on the same day without having to

Are services responsive to people's needs?

(for example, to feedback?)

pre-book an appointment. Patients we spoke with and comments we received all expressed confidence that urgent problems or medical emergencies would be dealt with promptly and staff would know how to prioritise appointments for them. The staff we spoke with had a clear understanding of the triage system to prioritise how patients received treatment, if they needed an appointment or how the GPs would decide to support them in other ways, for example, a telephone consultation or home visit. The practice also offered pre-bookable appointments in advance, online appointment bookings and had extended opening hours on certain week-day mornings and evenings. There was a system for patients to obtain repeat prescriptions and when we spoke with patients, they told us that they found the system worked well and their medicines were available when they needed them.

From our observations, discussions with patients and staff we saw that the practice had ensured that patients were able to access services in a way that was most suitable for them.

Concerns and complaints

We saw that the practice had a complaints policy and a procedure that set out how complaints would be addressed, who by, and the timeframes for responding. The policy and procedure reflected the requirements of the NHS complaints process and included the details of external bodies for complainants to contact if they preferred. The process was included in the practice information leaflet for patients. We saw a folder where complaints were recorded and a report that had been produced for the year, summarising emerging themes and trends and was discussed at management meetings to review any changes that could be made. For example, the introduction of the 'walk-in and wait' appointment system had generated a number of complaints and management had reviewed how this could be improved by making changes to the opening times and prioritising appointments for certain groups of patients.

We saw evidence that complaints, comments and patient feedback was used by the practice to monitor quality and safety and saw examples of learning points that had been used by management to implement changes. For example, a complaint had been received regarding the length of time taken for a patient to receive the results of their blood test. Consequently, a system was introduced to alert the reception staff to urgent blood tests and those that were considered routine, so that patients could be informed of when to expect their results.

From our observations, discussions with staff and patients, we found that the practice was responsive to comments, complaints and feedback to help inform how the service was provided in meeting the needs of patients.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Summary of findings

Overall, the practice was well-led. The management team provided open and visible leadership to the staff and there were clear lines of accountability and responsibility within the practice. There were mechanisms in place to disseminate information to the staff and procedures for reporting up the line management structure.

Our findings

Leadership and culture

We spoke with management at the practice, who told us that they advocated and encouraged an open and transparent approach in managing the practice and leading the staff teams. The GPs being equal partners, promoted shared responsibility in the working arrangements and commitment to the practice. Group lunches and social occasions were regularly held to promote a group ethos. The staff we spoke with told us that they felt there was an "open door" culture, that the GPs were "visible and approachable", that they felt supported and were able to approach the senior staff about any concerns they had. They said that there was a good sense of team work within the practice and communication worked well. We saw that a named GP had a pastoral lead role in supporting the clinical team.

Governance arrangements

The governance arrangements within the practice included the delegation of responsibilities to named GPs, for example, a lead for safeguarding, quality, prescribing, and clinical governance. This helped to clarify the role of each GP and provided structure for staff in knowing who to approach for support and clinical guidance when required.

Systems to monitor and improve quality and improvement

Governance/management meetings were held on a regular basis to consider quality, safety and performance within the practice. This included monitoring of complaints, comments and suggestions received from patients and issues raised by the patient participation group. Information from the practice 'Quality and Outcomes Framework' (QOF) was analysed and reviewed to enable the practice to make comparisons to national performance and locally agreed targets. Information from clinical audits was reviewed and actions taken to achieve potential improved outcomes for patients.

Patient experience and involvement

We saw that engagement with patients was managed through the patient participation group and we spoke with their representative during the inspection. They told us that management were responsive to suggestions and supported regular patient surveys to consider ways to improve the practice and make changes where it was

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

practicable to do so. We saw examples of where changes had been made in response to comments and feedback received from patients, including changes to improve the reception and waiting area for patients.

Staff engagement and involvement

Staff were encouraged to attend and participate in regular staff meetings and we saw evidence that regular meetings took place that included discussions about changes to procedures, clinical practice, and staff cover arrangements. We saw that the practice had a whistleblowing policy that provided staff with contact details of external authorities if they wished to report concerns outside of the practice.

Learning and improvement

We saw that patient referrals were discussed at clinical team meetings and learning points considered and shared between clinicians. The practice was designated as a 'learning practice' where trainee GPs were offered placements to develop their knowledge, skills and clinical competencies. We were told by the GPs that this was considered important to the practice in strengthening and supporting an exchange of learning and innovation amongst all clinicians. Records showed that clinical staff were supported to access on-going learning to improve their skills and competencies. For example, attending specialist training for diabetes, childhood immunisation and opportunities to attend external forums and events to help ensure their continued professional development. Information and updated guidance was also disseminated from a lead nurse within the NHS Trust to the clinical nurses at the practice. Non-clinical staff were also supported to improve their skills and knowledge, for example, attending specific courses in relation to prescription documentation and processing.

Identification and management of risk

We saw that systems and processes were in place to manage risks. Risk assessments were used to consider individual risks to patients and assessments were undertaken to consider and determine likely risks to the practice. We saw that the practice considered risks and ensured that they had processes in place to mitigate/ manage risk, for example, business continuity plans that included disruption/loss of the premises.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Summary of findings

Although we found that most of the staff had not received specific training for the safeguarding of vulnerable adults, they were able to demonstrate their awareness of the procedures to follow if any concerns were identified.

We saw that the practice offered annual flu vaccinations routinely to older people to help protect them against the virus and associated illness.

We found the practice to be caring in the support it offered to older people and there were effective treatments and on-going support for those patients identified with dementia. The practice was responsive in meeting the needs of older people and in recognising future demands in service provision for this age group. The practice was well-led in relation to identifying a named lead doctor to train in specialist dementia care and in recognising symptoms to enable early detection. There was a care manager from social services based at the practice which encouraged a joint approach to care for this population group.

Our findings

Safe

The practice provided annual flu vaccinations for older people, to provide on-going protection/prevention from contracting the virus and associated complications/illness.

The practice had a safeguarding policy that reflected the arrangements for protecting children as well as vulnerable adults from the risks of abuse. Although staff had received training in safeguarding children, we saw evidence that only one member of staff had received training in safeguarding vulnerable adults. This meant that staff may not always be able to recognise or have awareness to the risks of abuse for vulnerable older people.

We found that the practice did not always manage medicines safely, to help protect patients from the risks associated with medicines. This included:-

- Lack of systems and processes for the security and control of prescription pads
- Lack of record keeping and checks of the emergency equipment/medicine stocks kept on the premises and issued to GPs
- Lack of record keeping and checks of the equipment/ medicine stocks kept/stored in the dispensary
- Lack of a written protocol/risk assessment for access/ security of the dispensary, including the space/ environment

We found that the practice did not always have appropriate infection control procedures and systems in place to minimise the risks of cross infection for patients. This included:-

- Lack of detailed cleaning schedules to identify the checks undertaken in treatment rooms throughout the day
- Lack of records and evidence of an audit programme in accordance with the hygiene code - that identifies how the practice monitors and manages issues relating to cleanliness and infection control

Older people

We looked at some staff files and saw that appropriate safety checks had been carried out. Although the practice had a robust recruitment policy, we found that some files did not contain sufficient documented information about the staff employed, for example, photographic ID, references and employment history.

Caring

The practice had formal links with two local care homes and provided regular and on-going care and support to the residents as patients. This enabled the residents to have continuity of care in supporting them with on-going routine and more complex health care needs.

Effective

The practice had a system to identify patients who presented with symptoms that may indicate dementia. Follow-up blood tests would be arranged at the practice and a referral made to the specialist mental health nurse to carry out mental health assessments. Following diagnosis, the patient would be referred and linked to other support services, including the monthly memory clinic and a specialist support centre for patients with dementia. Patients were also referred by the practice to groups and clinics that provided on-going support and treatment for physical health care needs, including a foot care clinic and an exercise group.

Responsive

The practice acknowledged that the patients they supported included a significant number of older people, who may place higher demands on the practice as an ageing population group in the future, with associated health care needs and complex conditions. The management had therefore considered how future planning would respond to the needs of patients in this age group and had taken some actions to address this, for example, additional specialist training had been identified for a GP in relation to dementia training. There was also a care manager from social services based at the practice which meant that support and advice could be accessed quickly in relation to any social care needs.

Well-led

The practice had identified GPs to take lead roles in conditions that affected older people, including dementia, vascular disease, stroke, chronic breathing disorders and asthma. Specialist training had been identified/ undertaken, knowledge and best practice shared with other clinicians at the practice, to potentially improve outcomes for older people.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Summary of findings

We found the practice to be caring in the support it offered to patients with long-term conditions and that the care provided was effective, treatment pathways were monitored and kept under review by a multi-disciplinary team. We saw that the practice offered annual flu vaccinations routinely to people who may be at greater risk due to long term conditions, to help protect them against the virus and associated illness.

The practice was responsive in prioritising urgent care that people required and the practice was well-led in relation to improving outcomes for patients with long-term conditions and complex needs.

Our findings

Safe

The practice provided annual flu vaccinations for vulnerable people, including those with long-term conditions, to provide on-going protection/prevention from contracting the virus and associated complications/illness.

The practice had a safeguarding policy that reflected the arrangements for protecting children as well as vulnerable adults from the risks of abuse. Although staff had received training in safeguarding children, we saw evidence that only one member of staff had received training in safeguarding vulnerable adults. This meant that staff may not always be able to recognise or have awareness to the risks of abuse for vulnerable older people.

We found that the practice did not always manage medicines safely, to help protect patients from the risks associated with medicines. This included:-

- Lack of systems and processes for the security and control of prescription pads
- Lack of record keeping and checks of the emergency equipment/medicine stocks kept on the premises and issued to GPs
- Lack of record keeping and checks of the equipment/ medicine stocks kept/stored in the dispensary
- Lack of a written protocol/risk assessment for access/ security of the dispensary, including the space/ environment

We found that the practice did not always have appropriate infection control procedures and systems in place to minimise the risks of cross infection for patients. This included:-

- Lack of detailed cleaning schedules to identify the checks undertaken in treatment rooms throughout the day

People with long term conditions

- Lack of records and evidence of an audit programme in accordance with the hygiene code - that identifies how the practice monitors and manages issues relating to cleanliness and infection control

We looked at some staff files and saw that appropriate safety checks had been carried out. Although the practice had a robust recruitment policy, we found that some files did not contain sufficient information about the staff employed, for example, photographic ID, references and employment history.

Caring

We spoke with a number of patients who had long-term conditions and they were consistently positive about the care and support they received from the practice and the staff. They told us that their well-being was monitored and they were re-called for routine checks and follow-up appointments on a regular basis.

Effective

Patients with long-term conditions and complex needs were supported by the clinical nursing team at the practice, who referred patients to the long-term conditions nurse. They provided specialist care and treatments for specific conditions such as diabetes and breathing disorders and attended the weekly multi-disciplinary meetings at the practice. All relevant issues were discussed to ensure that patients received appropriate care and support. This meant that patients with long-term conditions were monitored and their treatment pathways kept under review.

Responsive

Patients we spoke with who had long-term conditions told us that when they required an urgent appointment, the practice ensured they were prioritised and would be able to see a GP quickly.

Well-led

We saw evidence that the practice undertook clinical audits to improve outcomes for patients with long-term conditions. The results were reviewed against national data to determine any changes that could be made to care/ treatment pathways and clinical therapies to improve outcomes for patients. The practice had nominated clinical leads for specific long-term conditions, for example, cardio-vascular disease, diabetes and epilepsy.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Summary of findings

There were systems and procedures at the practice to ensure that information received from other service providers was used to improve safety for babies, children and young people.

We found that the practice was caring in its approach to mothers, babies, children and young people and provided effective treatments, offering dedicated services at the practice and referrals to other community based services to provide additional support. The practice provided a responsive service, prioritising appointments for mothers with babies and young children. The practice was well-led in relation to nominating a named lead to have overall responsibility for children's safeguarding.

Our findings

Safe

We found that the practice did not always manage medicines safely, to help protect patients from the risks associated with medicines. This included:-

- Lack of systems and processes for the security and control of prescription pads
- Lack of record keeping and checks of the emergency equipment/medicine stocks kept on the premises and issued to GPs
- Lack of record keeping and checks of the equipment/ medicine stocks kept/stored in the dispensary
- Lack of a written protocol/risk assessment for access/ security of the dispensary, including the space/ environment

We found that the practice did not always have appropriate infection control procedures and systems in place to minimise the risks of cross infection for patients. This included:-

- Lack of detailed cleaning schedules to identify the checks undertaken in treatment rooms throughout the day
- Lack of records and evidence of an audit programme in accordance with the hygiene code - that identifies how the practice monitors and manages issues relating to cleanliness and infection control

We looked at some staff files and saw that appropriate safety checks had been carried out. Although the practice had a robust recruitment policy, we found that some files did not contain sufficient information about the staff employed, for example, photographic ID, references and employment history.

We were told by clinical staff that the computer system flagged up an 'alert' for babies and young children who had been placed on the 'at risk' register. We were also told that

Mothers, babies, children and young people

the system flagged up frequent visits to hospital A & E departments that were followed up by the practice. This meant that information received from other service providers was used to improve patient safety.

Caring

The practice supported the patient participation group to engage with mothers who had babies and young children. They had been asked for their views, comments and suggestions about the type of clinics, services and information they would like to see developed at the practice, for example, maternity issues, childhood illness and immunisation.

Effective

The practice had links and routinely made referrals for mothers with babies and young children to the community health visitor, providing an additional level of support. The practice also offered baby and child immunisations. Ante/post-natal services were provided at the practice by a designated midwife from the NHS Trust and they provided two clinics each week. A communication system was in place to alert the practice to births, following which a letter would be sent to the mother inviting them to attend a post-natal check with one of the two practice GPs who undertook maternity/post-natal care.

Responsive

The practice had introduced a 'walk in and wait' system every week-day morning that meant patients did not need to pre-book appointments. However, this meant that there were sometimes long waiting times in the reception/waiting area. Comments had been received from mothers and other patients, who felt that it was not appropriate for babies and young children to be kept waiting and the practice had subsequently introduced a system to alert the GPs when babies and/or young children were waiting to be seen. GPs were then able to prioritise appointments around these patients.

Well-led

The management at the practice had identified a named lead for safeguarding children who had specific responsibility for disseminating information and training to other staff within the practice. We saw that the practice had links to a named lead nurse at the NHS Trust for safeguarding children. Quarterly meetings were also held with the lead nurse for schools and the community health visitor to discuss/review child safeguarding issues that were known to the practice.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Summary of findings

We found the practice to be caring in the support it offered to working age and recently retired people, and were responsive in reviewing opening hours. There was effective monitoring of services and the management team completed audit cycles to evaluate and improve outcomes for patients in this group.

Our findings

Safe

The practice had a safeguarding policy that reflected the arrangements for protecting children as well as vulnerable adults from the risks of abuse. Although staff had received training in safeguarding children, we saw evidence that only one member of staff had received training in safeguarding vulnerable adults. This meant that staff may not always be able to recognise or have awareness to the risks of abuse for vulnerable people.

We found that the practice did not always manage medicines safely, to help protect patients from the risks associated with medicines. This included:-

- Lack of systems and processes for the security and control of prescription pads
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- Lack of a written protocol/risk assessment for access/ security of the dispensary, including the space/ environment

We found that the practice did not always have appropriate infection control procedures and systems in place to minimise the risks of cross infection for patients. This included:-

- Lack of detailed cleaning schedules to identify the checks undertaken in treatment rooms throughout the day
- Lack of records and evidence of an audit programme in accordance with the hygiene code - that identifies how the practice monitors and manages issues relating to cleanliness and infection control

We looked at some staff files and saw that appropriate safety checks had been carried out. Although the practice

Working age people (and those recently retired)

had a robust recruitment policy, we found that some files did not contain sufficient documented information about the staff employed, for example, photographic ID, references and employment history.

Caring

The practice supported the patient participation group to engage with working age patients. They had been asked for their views, comments and suggestions about the type of clinics, services and information they would like to see developed at the practice, for example, keeping healthy, prevention of heart disease, menopause, and managing the aging process.

Effective

The practice offered a range of services to provide monitoring and routine support for patients in this age group, including lifestyle and healthy living checks, blood pressure and diabetes checks.

Responsive

The practice had introduced extended opening hours and surgery times for patients who may find it difficult to attend appointments during core working hours. This included some early week-day mornings and evenings.

Well-led

The practice management team had systems in place to ensure clinical audit cycles were completed to highlight/ identify where improvements could potentially be made for specific groups of patients.

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Summary of findings

We found that the practice was caring about vulnerable patients, in particular, the premises were accessible and suitable for patients with reduced mobility. However, the height of the reception desk was not considerate to patients who used wheelchairs. We saw that the practice offered annual flu vaccinations routinely to vulnerable people as they may be at greater risk of infection, to help protect them against the virus and associated illness. There was effective support from the practice for vulnerable people in the community and the practice was responsive in providing care and treatment at patients' homes who found it difficult to attend the practice.

Our findings

Safe

The practice had a safeguarding policy that reflected the arrangements for protecting children as well as vulnerable adults from the risks of abuse. Although staff had received training in safeguarding children, we saw evidence that only one member of staff had received training in safeguarding vulnerable adults. This meant that staff may not always be able to recognise or have awareness to the risks of abuse for vulnerable people.

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People in vulnerable circumstances who may have poor access to primary care

We looked at some staff files and saw that appropriate safety checks had been carried out. Although the practice had a robust recruitment policy, we found that some files did not contain sufficient information about the staff employed, for example, photographic ID, references and employment history.

Caring

We observed that the premises enabled easy access for patients with reduced mobility. However, we saw that the reception desk did not have a lowered area to accommodate patients using wheelchairs, who may have found it difficult to communicate easily with the reception staff and may have felt their dignity was compromised.

Effective

The practice had formal links with a local care home for people with learning disabilities and provided regular and on-going care and support to the residents as patients. This enabled the residents to have continuity of care in supporting them with on-going routine and more complex health care needs associated with their disabilities.

Responsive

The practice recognised that some patients may find it difficult to attend the surgery for care and treatment. We were told that the practice informed the community nurses if this was the case, and they would support and treat patients at home if they were housebound. This enabled patients with limited access and mobility to receive appropriate care and treatment in their homes.

Well-led

The management team recognised and acknowledged that the practice had very few identifiable vulnerable patient groups within the locality of the practice. However, where patients were identified as particularly vulnerable, mechanisms had been put in place to help ensure equality of access to the practice and the services provided. For example, translation/interpretation services were accessible for people who had communication difficulties.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Summary of findings

We found the practice had a caring approach to patients who may be experiencing poor mental health and the practice had effective procedures in place for undertaking routine mental health assessments. They were responsive in referring patients to specialist mental health service providers for on-going support. Management provided a well-led approach in relation to identifying and managing risks to patients who may be experiencing poor mental health.

Our findings

Safe

The practice had a safeguarding policy that reflected the arrangements for protecting children as well as vulnerable adults from the risks of abuse. Although staff had received training in safeguarding children, we saw evidence that only one member of staff had received training in safeguarding vulnerable adults. This meant that staff may not always be able to recognise or have awareness to the risks of abuse for vulnerable people.

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- Lack of records and evidence of an audit programme in accordance with the hygiene code - that identifies how the practice monitors and manages issues relating to cleanliness and infection control

We looked at some staff files and saw that appropriate safety checks had been carried out. Although the practice

People experiencing poor mental health

had a robust recruitment policy, we found that some files did not contain sufficient documented information about the staff employed, for example, photographic ID, references and employment history.

Caring

The practice supported the patient participation group to engage with patients who may have mental health needs. Patients had been asked for their views, comments and suggestions about the type of clinics, services and information they would like to see developed at the practice, for example, talks from specialists about mental health, and how to cope with depression.

Effective

We were told by staff that the practice undertook mental health assessments as part of other routine health checks. This helped to identify mental health issues and early detection for patients who would then be referred to specialist services and receive on-going support.

Responsive

The practice held weekly multi-disciplinary meetings to consider individual patient's needs, including those who may be experiencing mental health issues. If concerns were identified, a referral was made to the specialist mental health nurse, who would provide appropriate support/interventions.

Well-led

The management team had systems and procedures in place to identify and manage risks to individual patients and included those who presented with poor mental health.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 – Requirements Relating to Workers. **How the regulation was not being met:** Patients who used the practice and others were not protected against the risks associated with the recruitment of staff who may be unfit or unsuitable for their role because the provider had failed to obtain sufficient information about the staff they employed, as required under schedule 3. Regulation 21(b)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 – Requirements Relating to Workers. **How the regulation was not being met:** Patients who used the practice and others were not protected against the risks associated with the recruitment of staff who may be unfit or unsuitable for their role because the provider had failed to obtain sufficient information about the staff they employed, as required under schedule 3. Regulation 21(b)

Regulated activity	Regulation
Family planning services	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 – Requirements Relating to Workers. **How the regulation was not being met:** Patients who used the practice and others were not protected against the risks associated with the

This section is primarily information for the provider

Compliance actions

recruitment of staff who may be unfit or unsuitable for their role because the provider had failed to obtain sufficient information about the staff they employed, as required under schedule 3.

Regulation 21(b)

Regulated activity	Regulation
Maternity and midwifery services	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 – Requirements Relating to Workers. **How the regulation was not being met:** Patients who used the practice and others were not protected against the risks associated with the recruitment of staff who may be unfit or unsuitable for their role because the provider had failed to obtain sufficient information about the staff they employed, as required under schedule 3. Regulation 21(b)

Regulated activity	Regulation
Surgical procedures	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 – Requirements Relating to Workers. **How the regulation was not being met:** Patients who used the practice and others were not protected against the risks associated with the recruitment of staff who may be unfit or unsuitable for their role because the provider had failed to obtain sufficient information about the staff they employed, as required under schedule 3. Regulation 21(b)